Philippine TIPS
TUBERCULOSIS INITIATIVES FOR THE PRIVATE SECTOR
A PROJECT SUPPORTED BY USAID

RAPID ASSESSMENT OF SINGLE-PRACTICE MODELS

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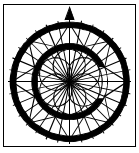

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TABLE OF CONTENTS

ACRONYMS

ANC	antenatal care
BCC	behavior change communications
CBRHA	community-based reproductive health auxiliaries
CMS	Commercial Market Strategies project
CYP	couple year of protection
DOTS	directly observed therapy-short course
FP	family planning
GP	general practitioner
IEC	information, education and communication
IUD	intraurine device
KAP	knowledge, attitudes, and practice
KIMET	Kisumu Medical Education Trust
KSM	Key Social Marketing
MCH	maternal and child health
MD	medical doctor
NGO	non-governmental organization
NTP	national TB program
OC	oral contraceptives
OT	operating table
PAC	post abortion care
PSI	Population Services International
RH	reproductive health
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
TFP	temporary family planning
TIPS	Tuberculosis Initiatives for the Private Sector
VCT	voluntary counseling and testing

Executive Summary

Traditionally, governments and donors have focused on improving service delivery in the public sector or through not-for-profit non-governmental organizations. More recently, recognition that the private sector provides health services to significant percentages of the population in many countries, including the poor, has led to programs to strengthen private sector services provision.

This desk study considers efforts to improve health outcomes through programs that support single, for-profit health practitioners such as a doctor, a nurse, etc. (Note: It does not examine models of improving health outcomes with public or private not-for-profit providers, with groups of private practitioners, or with pharmacies, which were covered in a previous desk study.) This assessment presents the following:

- Support options and model types
- Case studies
- Lessons learned and recommendations for the Philippine TIPS project

Twelve case studies are presented for initiatives in Ethiopia, Kenya, India, Nepal, Pakistan, Uganda, and Zimbabwe. The health services strengthened by these initiatives are diverse, though most focused on reproductive health. The initiatives themselves are even more diverse, ranging from a medical association providing training to its members and a microcredit institution providing credit and basic business training to health sector borrowers to full-blown social franchises. Documentation on these initiatives was reviewed to understand how many and what types of private practitioners were affected by the program; what services were provided; and what lessons have been learned.

The lessons learned section summarizes what was learned from the documentation about:

- Demand generation via awareness campaigns, promoting qualified practitioners, and dealing with cultural issues
- Developing quality service provision models, including attracting and selecting appropriate practitioners, developing training programs, ensuring provision of high quality services and adherence to standards, and developing referral systems
- Retaining members
- Sustainability

Several conclusions can be drawn regarding single practitioner provision of DOTS in the Philippines. Training, monitoring, a referral system, branding and significant promotion of DOTS in general and qualified practitioners specifically will be important elements in creating robust supply and demand for private sector DOTS delivery in the Philippines. TIPS will need a model that offers these five elements. A fractional franchise might best meet this need. The recommendations offered could best be packaged in a franchise, but could also be advanced independently.

Rapid Assessment of Single-practice Models

The Philippines Tuberculosis Initiatives for the Private Sector (TB TIPS) seeks to reduce the prevalence of tuberculosis in the Philippines by increasing the successful diagnosis and treatment of TB patients with a cure rate of at least 85% using directly observed therapy-short course (DOTS) through commercial private sector services. One important aspect of the TIPS project will be single-practice DOTS models. There is considerable evidence that a high percentage of those who seek treatment for TB in the private sector obtain care through small, single-practice clinics. Reaching these physicians and enabling them to provide DOTS to their patients will greatly increase the number of Filipinos receiving proper and effective TB treatment. This study assesses world-wide experience with single-practice approaches that support individual health practitioners' use of best health care practices.

The assessment considers efforts to improve health outcomes by working with single, private, for-profit health practitioners such as a doctor, a midwife, a nurse, an auxiliary nurse-midwife, etc. It does not examine models of improving health outcomes with public or private not-for-profit providers, or with groups of private practitioners (as in a hospital or a polyclinic). Other TIPS assessments are examining models for supporting pharmacists and single, private, not-for-profit practitioners in the Philippines, so these models are not repeated here.

This assessment presents the following:

- Support options and model types
- Case studies
- Conclusions and recommendations for TIPS

A. Support Options and Model Types

Traditionally, governments and donors have focused on improving service delivery in the public sector or through not-for-profit non-governmental organizations since both of these providers are assumed to target the poorest of the poor and others with limited access to care. Additionally, because demand is strongest for curative care for acute episodes, program managers have rightly concluded that for-profit practitioners focus on such services rather than preventive services or treatment of chronic diseases.

Recently, interest has grown in supporting private, for-profit practitioners. It is recognized that they provide health services to significant percentages of the population in many countries, including the poor, they don't face the same challenges to improving quality of care as the public sector, they can be more efficient, and a strong private sector may siphon poor and middle income patients off the public sector, leaving the public sector to focus on the very poor.

Because of the relatively recent interest in the private sector, donors and governments in developing countries have limited experience supporting private practitioners. The oldest

examples we identified started in the last decade; indeed, most started in the last few years. Support programs for private health practitioners are still very much in the experimentation phase and many basic questions are still being explored by program managers and donors.

The bulk of the support programs we examined focus on expanding private practitioner provision of quality reproductive health services. This has attracted the most funding from the U.S. government and private donors, which have been the most active in supporting the private sector. Typically, child health and infectious disease service strengthening has been confined to the public or not-for-profit sector, though this is changing.

There are few established models for supporting private practitioner achievement of improved health outcomes. Programs offer a wide variety of support options, as follows:

- Medical training
- Other training (generally business management or marketing)
- Supervision/monitoring to ensure quality and conformance with standards
- Accreditation
- Involvement in referrals so that practitioners are linked to other levels of health service delivery related to the health need being addressed
- Supplies (medicines, equipment, information, education and communication [IEC] materials, etc., either at subsidized or cost recovery rates)
- Credit
- Branding to identify and promote products or services
- Marketing ranging from general behavior change communication to specific marketing of network services or products
- Research from formative to market and operations research
- Policy advocacy to address barriers to private provision or marketing of services

Programs offer various combinations of these support services to private practitioners. At a minimum, almost all include an element of medical training, generally coupled with one or more other support services. At the other end of the scale, a full-blown services franchise model includes all or almost all the support services listed here. In between, there is great variation in the combination of services rather than a continuum where support services are added in a consistent progression.

Most – though not all – involve some sort of provider network or "affiliated group of health providers that operate under an umbrella brand that signals a defined package of services at set prices with a reliable quality of care." A franchise is a tightly organized network built around a business contract between a franchiser and franchisees that deliver services according to the franchise specifications. The franchiser provides training, ongoing technical support, and franchise promotion. Fractional franchises, in which franchisees provide franchise services as part (or a fraction of) their total menu of services, are the most commonly seen in commercial provision of health services.

As the case studies show, there is no magic model for success in supporting the private sector. Success is achieved by targeting particular constraints given the level of the service provider, the nature of the health service being provided, and the nature of the market.

B. Case Studies

We present in Annex A twelve case studies of efforts to improve health outcomes by supporting single, private, for-profit health practitioners. Most of these efforts are relatively new and only a few have been studied extensively, so the information available varies considerably. We present what is known about each, focusing on lessons learned that may be useful to TIPS.

We provide information in as many of the following categories as possible:

- Model name – the country in which the model was implemented and the name of the program
- Model type – a classification of the type of support program
- Health services delivered – the health issues addressed by the program
- Start date – what year the program started
- Provider types – the type of health specialist (doctor, nurse, etc.) supported by the program
- Number of providers – how many providers are supported by the program
- Member recruitment/selection criteria and process – how providers were identified or selected to participate in the program
- Services provided by the support entity – identical to the list mentioned in Section B above
- Commitments of single practice members – what members of the program are required to contribute to the program. This includes payment for training, participation in regular training, reporting to the support entity, participation in a referral system, interest payments on credit, a membership or franchise fee, and input into decision-making on the program
- Client perception of model members – how do clients view the single practitioners who are members of the program?
- Single practice member perception of the value of the model – what do members value most highly in the model?
- Results – health outcomes achieved by the program
- Lessons learned that can inform other single practitioner programs
- Sources – the materials referenced in developing the case study

Case studies for the following programs supporting single practitioners appear below:

- Ethiopia Biruh Tasfa family planning/reproductive franchise
- India Bihar State Janani franchise
- India Goli ke Hamjoli campaign
- Indian Medical Association family planning clinical training program

- Kenya Nyanza Province sexually transmitted infection (STI) treatment training program
- Kenya Kisumu Medical Education Trust franchise
- Nepal nurse and paramedic fractional franchise
- Nepal Lalitpur public-private partnership for DOT treatment
- Pakistan Green Key social marketing network
- Pakistan Green Star franchise
- Uganda midwives microfinance scheme
- Zimbabwe HIV/AIDS voluntary counseling and testing (VCT) services public, commercial, and NGO franchise

Single Practice Profile

Model Name: Ethiopia Biruh Tasfa FP/RH Private Clinics (Pathfinder)

Model Type: Franchise

Health Services Delivered: broad FP/RH with emphasis on post abortion care

Start Date: 2000

Provider Type(s): community based reproductive health auxiliaries (CBRHAs), promoters

Number of Providers: 69 private clinics; 264 CBRHAs; 76 marketplace promoters working in 42 marketplaces; 62 workplace peer promoters working in 19 workplaces

Services Provided by Support Entity:
Medical Training: The program provided FP/RH update training to 131 providers; emergency care and PAC to 113; quality of care to 66; norplant insertion/removal to 55; STD syndromic management to 54; CBRH supervisory training to 46; voluntary surgical contraception to 34; and IUD insertion/removal to 19.

Supervision/monitoring: supervision is provided

Supplies: The project provided clinical equipment, bags, radio cassettes, metal boxes, canvas shades, uniforms (for promoters), and posters and stickers with logo. It also improved the availability of commodity supplies.

Branding: Biruh Tasfa logo

Marketing: The franchise held 16 community sensitization meetings, did multi-media work, and sponsored community theatre.

Other: The franchise helped form an association of private providers. It also supported franchisee facility upgrades.

Client Perception of Model Participants: A study of Janani, Greenstar and Biruh showed that clients at franchises are more willing than are clients at non-franchise private establishments to use the same establishment for their next visit, less likely to cite affordability, and more likely to visit for FP, RH, MCH and medicines than for general care.(Bardsley)

Results: By end of phase I (2000-2002), the program had reached 290,000 people, assisted 42,000 new clients, and provided 16,167 CYPs.

The franchises experience higher revenue from temporary FP services than private non-franchised establishments and pharmacies, even though pharmacies have more FP client volume. Cost per user of TFP at franchise establishments is lower or comparable to both private non-franchised, NGO, and government sites. User costs were still lower at pharmacies due to lower salary costs in pharmacies. (Stephenson)

Lessons Learned:

Some clinics initially brought into the program have lost interest. The franchise must have a mechanism and the willpower to replace them.

The franchise initiative had to be modified to include infrastructure development to address franchisees' significant infrastructure needs.

Sources:

1. Giday, Tilahun, "Pathfinder International – Ethiopia: FP/RH Private Sector Initiative," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

2. Bardsley, Phil, "Franchise Quantity and Quality Outputs: Evaluation Results," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

3. Stephenson, Rob, "Cost Analysis of ABM Data," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

Single Practice Profile

Model Name: India Goli ke Hamjoli (Friends of the Pill)

Model Type: social marketing

Health Services Delivered: low dose oral contraceptives

Start Date: 1998

Provider Type(s): pharmacists and doctors

Number of Providers: 30,000 pharmacists and 22,000 traditional doctors

Services Provided by Support Entity:
Medical Training: Public relations and training activities were targeted at pharmacists and doctors, considered the "gatekeepers" and key opinion leaders for oral contraceptive use. Promoters provide specific information about low-dose OCs to doctors and pharmacists, and answer questions about the difference between the new, low dose pills and older, higher-dose pills.

Additionally, briefing sessions have been held in 12 cities for leading local civic groups including the Indian Medical Association, the Rotary Club, and others. Updates on the program have been mailed to over 27,500 doctors. More than 320 of the area's top doctors have endorsed the campaign.

Marketing: CMS developed a mass media consumer campaign plan to promote "generic" use of low-dose OCs through advertising and public relations. Commercial and social marketing firms could promote their own brands under the general umbrella of the campaign. Mass media campaigns included celebrity endorsements.

Research: CMS conducted research among OC users and potential users to understand the needs and fears regarding OCs and to identify the target audience. Subsequent research expanded the target audience.

Results:

Television ads have over 80% recall among target women in program cities. Recent sales data show that the campaign has been successful in growing the OC market within the target audience.

Sales of OCs had reached a plateau, so the campaign was introduced. There was a two year time lag between the start of the campaign and the changed perceptions, so changed perceptions probably were due to diffusion of information from new users. Program managers could not conclude that the generic BCC campaign would lead to continuing

increases in sales. It did overcome the initial sales plateau, but OC sales might have reached a second, higher plateau. (Meekers)

Lessons Learned: Generic behavior change campaigns can be helpful in increasing demand for single practitioners' business. Short training of medical practitioners that builds their acceptance of a medical method, accompanying a significant awareness campaign to initiate consumer demand, can lead to meaningful increases in family planning.

Sources:

1. Meekers, Dominique, "Growing the Market after Family-Planning Product Sales Plateau: An Assessment of Approaches," CMS presentation made at USAID. June 10, 2003, Washington, D.C.

2. "Friends of the Pill: Expanding the Market for Oral Contraceptives in North India," CMS New Directions in Reproductive Health, Vol. 2, No. 1, October 2001.

Single Practice Profile

Model Name: India Bihar State Janani

Model Type: social franchise

Health Services Delivered: family planning services. Surya clinic practices are expanding to provide other health services.

Provider Type(s): rural medical providers (in Titli Centers); auxiliary nurse midwives and medical doctors (Surya clinics); and shop owners (20% of whom are chemists)

Number of Providers: 20,000 rural medical providers (2 per village); 498 medical doctors; and up to 44,000 shops. (Vachani)

Member Recruitment/Selection Criteria and Process: The network preferred experienced and established providers. Surya clinic providers sampled by an outside reviewer were mostly in their late 30s, early 40s, with 12-15 years of professional experience. Nearly all Surya and Titli providers owned their clinics, another selection criteria as evidence of commitment to clinic success. (Montagu)

Services Provided by Support Entity:
Medical Training: The franchise provides 3 days of training in a regional training center for rural medical providers and 3-5 days of training for medical doctors at a clinic. Quality of care training includes counseling, lab facilities, infection detection and control, and waste disposal.

Supervision/monitoring: Titli centers are visited every three months by monitors who track things like cleanliness and availability of basic printed materials. If the provider fails to score well on two consecutive occasions, he is replaced by a back-up provider.

Involvement in referrals: Rural medical providers in the Titli Centers are supposed to refer patients to the Surya clinics for insertion of IUDs, sterilization, and abortion. Referrals receive a commission.

Supplies: Surya Clinics get an initial investment for painting, signage, and basic equipment (posters, a consulting table and chair). They must have a basic set of clinical equipment, and can buy replacements through Janani-designated distributors at below-market prices due to group purchases by Janani.

Branding: The clinics and centers are branded and the franchise widely marketed.

Marketing: 45% of the budget is earmarked for IEC. Mass media reach to the target audience is limited, so Janani uses the mass media to communicate with providers and to provide credibility to the networks. IEC focuses on local level activities. (Vachani)

Commitment of Single Practice Member:
Membership or franchise fee: Titli members were charged a membership fee of $12/year starting in year two (Gopalakrishnan). More than 80% of the Titli Centers were paying membership fees. (Vachani) Members can reduce their membership fees by up to 50% with early payment. Surya clinic members are not charged a membership fee.

Other: Prices for Surya clinics are fixed by Janani and widely advertised. Failure to sell a sufficient quantity of goods and services can result in expulsion from the franchise. (Montagu)

Client Perception of Model Participants: A study of the Janani, Greenstar and Biruh franchises showed that clients at franchises are more willing than are clients at non-franchise private establishments to use the same establishment for their next visit, less likely to cite affordability, and more likely to visit for FP, RH, MCH and medicines than for general care. (Bardsley)

Titli clients were most likely to choose their provider because the center was easy to get to (almost 60%), followed by low cost and knowing the provider (about 30% each). (Montagu)

Surya clients were most likely to choose their provider due to his reputation (50% of respondents cited this), followed by knowing the provider (47%) and because the clinic was easy to get to (about 30%). (Montagu)

Single Practice Member Perception of Value of Model:
Approximately 35% of Surya members cited training as the most important benefit of membership; 24% cited advertising; 17% cited increased clients; 14% cited interaction with other providers; under 10% each for subsidy and knowledge of service competitors. (Hetherington)

Approximately 71% of Titli members cited training as the most important benefit of membership; 13% cited advertising; under 10% each for increased clients, subsidy, knowledge of service competitors, and interaction with other providers. (3) One third report an increase in community esteem for their practices. (Bishai)

An outside study found that incomes for family planning services are large and these services have shown themselves to be highly profitable in this and several other franchise settings. In the Janani franchises, there is a significant correlation between overall network valuation by members and income from family planning services. An outside researcher concluded this is due to the fact that the Janani franchise model emphasizes operation of centers and clinics as business operations. (Montagu)

Results: The Janani franchise expects to deliver 2 million CYPs in 2 years, of which 40% are from clinical services; 33% are condoms and OCs in rural areas. They also expect to upgrade 200 clinics with auxiliary nurse-midwives, counselors, and lab facilities. (Gopalakrishnan)

In 2001, the centers and clinics sold almost 25 million condoms, and 7 million pills, and provided 870,000 CYPs. (Vachani)

In a study, approximately 31% of clients recognized the Titli logo and 13% the Surya logo. Approximately 57% and 63% of knowledgeable clients associated the Titli and Surya logos (respectively) with family planning services. Client education was more important to recognition of logo than age or income, but there was highest recognition of the Surya logo among upper income levels. Branding significantly increased a client's odds of going to a Titli or Surya site for RH services. Branding also significantly increased use of franchise sites for RH and non-RH services by being associated with FP services and affordability. (Tsui)

Lessons Learned:

*Bundling of Services***:**
Janani has determined it needs 3 different delivery platforms, from shops to centers to clinics. 44,000 shops that will sell condoms, oral pills, and possibly provide injectables, mainly in urban areas. Titli Centers in rural areas will sell condoms and pills, do dipstick diagnostic and screening tests, and refer clients to clinics for a commission. Surya Clinics will provide family planning services (from abortions to sterilizations, injections, gynecological procedures and general health services) with auxiliary nurse midwives inserting IUDs and supporting normal deliveries. Ten percent of the Surya clinics will be specialist clinics with better skills, equipment and facilities. (Gopalakrishnan)

Surya clinics are the weakest link. Clinical services need to be strengthened. Only 1/3 of clinics had any kind of an operating table, but clinics weren't interested in investing in OTs just for sterilizations. The Surya clinic program is expanding to offer emergency obstetric care, immunization, and essential clinical services to justify doctors' investments in OTs. (Gopalakrishnan)

Janani found it was useful to bundle products and services, especially if they're new. For example, if the program is trying to build a market for injectables, don't have clients go buy the injectable in one place, then bring it to a service provider for the injection. Clients will never go through all those steps with a new product. Rather, have the injectables available at the site where the injections are to be made.

Franchise Value to Members:
Janani found people are willing to pay much more for clinical services than for non-clinical services. One observer concluded that social service marketing will be more financially sustainable than social product marketing for this reason.

Providers will only be interested if the health service is financially viable. If there is a lot of volume/demand for a service, providing that service can be attractive even if the price is low. If there's not much volume/demand, prices will have to be high to interest providers. ("Marketing Reproductive Health Services…")

Establishing the network is not as difficult as sustaining it. Aggressive advertising in the early stage of network development can attract provider interest. But members will only stay with the network if it makes financial sense. In the Janani case, the Surya clinics are able to charge higher prices, and they will probably have greater longevity in the program than the Titli Centers, which cannot provide the higher priced clinical services. ("Marketing Reproductive Health Services…")

One observer noted that some of the Titli Center staff started providing clinical services on the basis of the little training they had received, rather than referring clients to the Surya clinics. They could make more by providing the services themselves than they received as an incentive fee from the clinics. (Maitra)

One analyst concluded that low end providers (like Titli providers) know their competition is more fierce – more like a commodity market. Franchise membership offers them more. The value of advertising and membership in all franchises increases as provider training (and skill level) decreases. Similarly, training and certification is more important among lower level providers than they are for Ob/Gyns and MDs. (Montagu)

Charging a membership fee from the very outset allows the program to monitor its value to members. If members didn't find the program valuable, they wouldn't continue to pay to be members.

Ensuring Quality:
Janani uses competition between providers to ensure quality of care. For example, in every rural village, there are two providers in the Titli centers so the public has a choice.

Janani monitors its far-flung activities by outsourcing the monitoring and quality control function. They have divided Bihar state into six regions, and have contracted entrepreneurial groups to track achievement of a limited number of indicators. A rival agency checks 25 percent of the indicators in a region to ensure the performance of the regular contractor. Bad performance by one agency results in a reward to the agency that did the checking. ("Marketing Reproductive Health Services…")

Quality of care is also ensured by communicating extensively with the public about the kind of services they should receive and at what prices. The community helps monitor services.

Marketing:
Mass media was useful at the outset of the program to attract providers and to give the program credibility among clients. Over time, Janani has reduced its use of mass media due to its cost.

Referral Challenges:
Observers of the program noted that some shops and Titli center staff were providing clinical services though they were supposed to refer patients requiring these services to

the Surya clinics. They had received an orientation to the clinical services as part of their training. Contrary to the program plan, they preferred to provide and charge directly for these services rather than refer patients and receive the smaller referral commission. They were not adequately prepared to provide the services. Four lessons from this might be to: (1) be very careful about the training provided to lower level providers so they don't try to overreach in the services they provide; (2) emphasize in the promotional campaigns that only certain providers are qualified to provide the more difficult clinical services; (3) monitor referrals rigorously; (4) make the referral fee attractive. (Maitra)

Sources:

1. Bishai, David. 2002. "Improving Quality and Access in Private Sector Primary Health Care – The Role of Business Models." World Bank.

2. Tsui, Amy, "Franchise Branding: Benefits and Challenge," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

3. Hetherington, John, "Greenstar KAP: Reproductive Health and HIV/AIDS Survey," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

4. Gopalakrishnan, Gopi, "Janani – Way Ahead," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

5. Vachani, Neelam, "Alternate Business Model: Janani," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

6. Bardsley, Phil, "Franchise Quantity and Quality Outputs: Evaluation Results," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

7. Stephenson, Rob, "Cost Analysis of ABM Data," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

8. "Marketing Reproductive Health Services: Moving Beyond Traditional Social Marketing," Technical Advisory Group Meeting, CMS, May 3, 2001.

9. Interview with Dr. Kuhu Maitra, who visited Janani sites and interviewed Title Center and Surya clinic staff in 2001.

10. Montagu, Dominic, "Provider Motivation in Social Franchises," presentation at the meeting on Social Franchising of TB and TV/HIV in Low Resource Settings, The Rockefeller Foundation, New York, April 28-29, 2003.

Single Practice Profile

Model Name: Indian Medical Association Family Planning Clinical Training, Gujarat

Model Type: Training provided by medical association

Health Services Delivered: Family planning – especially IUDs

Start Date: 1994, assessed in 1995

Provider Type(s): physicians

Number of Providers: 1400 members of the Indian Medical Association (IMA) received training in level 1. Of these, 147 physicians requested and 100 were selected to receive training in level 2.

Services Provided by Support Entity:
Medical Training: The competency-based participatory training course provided technical knowledge and skills to provide comprehensive child-spacing services. Level 1 training consisted of 18 hours of workshop and simulated practice to provide a technical overview of all contraceptive methods available in India with emphasis on oral contraceptives and family planning counseling. Level 2 training consisted of 24 hours of workshop and 18 hours of clinical practice with insertion and removal of IUDs, screening for genital tract infections, and infection prevention.

Commitment of Single Practice Member:
Payment for training: Every trainee paid 100 rupees to attend the course.

Results: An assessment of trainer and trainee perceptions, performance, and knowledge nine months after the provision of training yielded the following:

- The average number of IUDs inserted post-training was low so delivery of IUD services had not expanded.
- All the trainees were from urban areas, so expansion into rural areas was not a result.
- There was no systematic training documentation, monitoring and evaluation of trainee performance, and refresher education to maintain and update skills.
- Both trainees and trainers performed very well on the counseling portion of the assessment (90% of trainees and 100% of trainers, role-playing with the Zoe model).
- Only 45 % of trainees and 50% of trainers received satisfactory performance ratings for IUD insertion.

Lessons Learned:

- Baseline data should be collected through a training needs assessment, and training objectives clarified and reviewed. Both of these should contribute to establishing selection criteria for trainers, training sites, and trainees.
- Greater care should be taken in selecting trainees to include an urban/rural mix.
- Greater care should be taken in training doctors with sufficient potential volume for IUDs. It might also be important to give priority to women physicians if there is a client bias against having male doctors insert IUDs.
- The number of practice insertions of IUDs should be more than 10; with only 10 practices, most trainees were not competent or confident.
- The IMA should develop quality assurance mechanisms and processes. These might include periodic review of clinical standards, guides and guidelines or supportive supervision and peer review.
- Trainers have to be competent. Trainers and trainees need to work with live patients and not just the Zoe model.

Sources:

Shibley, Lynn, and Bimal Buch, PRIME Project Technical Report 2: "Follow-up Assessment of the Indian Medical Association (IMA) Family Planning Clinical Training Course in Gujarat." September 1995.

Single Practice Profile

Model Name: Kenya Kisumu Medical Education Trust (KIMET)

Model Type: social franchise

Health Services Delivered: reproductive health and contraceptives

Start Date: 1996

Provider Type(s): obstetricians-gynecologists, general practitioners, clinical officers, nurse midwives, community health workers

Number of Providers: 160 professional health providers and 300 community health workers

Services Provided by Coordinating Body:
Medical training: 5 day training in reproductive health

Supervision/monitoring: monthly visit by a KIMET staff supervisor

Supplies: supply of government-issued contraceptives

Credit: access to $1000 loan at low interest from revolving fund

Marketing (advertising, logo, signage): advertising

Client Perception of Model Participants: Focus groups show clients can detect improved quality of care. Clients cited reputation for quality as the most important reason for visiting a franchise member.

Single Practice Member Perception of Value of Model: Single practice members value most highly the professional satisfaction of learning to improve their services. They also value their membership for financial reasons.

Lessons Learned:

As other studies show, members often place the highest value on training provided by a franchise.

Sources:

Bishai, David. 2002. “Improving Quality and Access in Private Sector Primary Health Care – The Role of Business Models.” World Bank.

Single Practice Profile

Model Name: Kenya Nyanza Province private treatment of sexually transmitted infections (STIs)

Model Type: training

Health Services Delivered: syndromic management of STIs

Start Date: 1998

Provider Type(s): licensed private doctors and nurses

Number of Providers: 600

Services Provided by Support Entity:
Medical Training: Training in syndromic management of STIs was provided.

Results: Before and after observation of the trainees showed a marked improvement in trainee application of the 4Cs (counseling, compliance, condoms, and contact treatment), especially among nurses but less so among doctors.

Lessons Learned: Less than one third of people with STIs sought treatment. Of those, only 17% received care from one of the providers trained in the program. To significantly improve health outcomes, it's important to promote the changed behavior (for example, seeking treatment for a suspected STI) and to build awareness of which providers are qualified to provide the services via publicized accreditation or branding of the trained providers.

Sources:

"Treating STIs in Kenya: The Role of the Private Sector," Futures Group Briefing, November 2002.

Single Practice Profile

Model Name: Nepal nurse and paramedic franchise

Model Type: Fractional franchise

Health Services Delivered: Reproductive health (family planning, ante-natal care, sexually transmitted infection services)

Start Date: Fall 2001

Provider Type(s): nurses and paramedics

Number of Providers: 64

Member Recruitment/Selection Criteria and Process: The project selected nurses and paramedics who had been previously trained to provide injectable contraception.

Services Provided by Support Entity:
Medical Training: Training focused on improving quality of care and expanding the range of provider services. Members received an intensive 7-day reproductive health training in clinical and non-clinical methods, side-effects management, family planning counseling, ante-natal care, and STI identification and counseling.

Other Training: Members received a 2-day training in services marketing: relationship marketing (trust, bonding), external marketing (mass media, promotions), emphasis on service quality and word of mouth, and development of a marketing plan.

Supervision/monitoring: A field coordinator visits members every month for monitoring. Mystery clients will be used to monitor quality of service.

Involvement in referrals: The nurse and paramedic network is to be linked to the existing physician network through a referral system.

Branding: The program was linked with a social marketing project, but external marketing activities were delayed.

Marketing: Providers were trained to do their own marketing in addition to the marketing of the franchise.

Commitment of Single Practice Member:
Membership or franchise fee: Members pay a registration fee and monthly dues

Client Perception of Model Participants: Clients' perceptions were surveyed nine months after the program started. The marketing of the franchise had been delayed, so only 14% of female clients and 7% of male clients knew their provider was a member of

the franchise. Those who were aware of the provider being a member of the franchise were more likely to make a RH visit.(Agha and Balal)

Based largely on the practitioners' personal marketing of their services, within nine months there were measurable increases in clients' perceptions of quality. 82% of women (as opposed to 37% before the program) cited the provider's caring manner as a reason for choice of clinic; 70% versus the previous 65% cited the provider's expertise as a reason; and 38% versus the previous 26% cited their personal knowledge of the provider as a reason. (Agha and Balal)

Results: Availability, quality and use of RH services improved in just nine months in spite of low awareness of the franchise brand. Provider training and provider personal marketing were able to achieve this. (Agha and Balal)

Lessons Learned: Improvements in provider skills and training providers to market their own services can lead to increases in client demand for services and perception of quality of services in a relatively short period of time.

Sources:

1. Berg, Ruth, "Private Provider Networks Supported by the Commercial Market Strategies Project," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

2. Agha, Sohail and Asma Balal, "Monitoring the Performance of a Reproductive Health Fractional Franchise in Nepal," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

3. CMS brochure "Provider Networks: Increasing Access and Quality of Care."

Single Practice Profile

Model Name: Nepal Lalitpur Public/Private Partnership

Model Type: service linkage or referral system to improve treatment outcomes for TB patients initially seeking care in the private sector

Health Services Delivered: DOT

Provider Type(s): Actual providers of DOT are staff in five DOT centers. Single practitioners refer patients to the centers.

Number of Providers: All 98 private physicians in the pilot area were invited to a workshop on the service linkage project.

Services Provided by Support Entity:

(Note: the services described here are provided to the single practitioner, not to the DOT clinic staff. Our focus is only on assistance to single practitioners.)

Involvement in referrals: Private practitioners were told to refer patients to the DOT centers and understood they would be kept informed of patients' progress. Patients are to be referred back to the private practitioner after treatment. A quality diagnostic center was set up in collaboration with an NGO. Private practitioners were encouraged to refer their chest symptomatics to the diagnostic center, which offered free sputum microscopy.

Other: The project developed a management protocol for the diagnosis of pulmonary TB, incorporated into a clinical manual. The project also provided a map showing treatment locations and guidelines for referrals. The manual was given to all doctors and the services linkages program was described at a national conference. All private doctors and pharmacists were visited during the year to inform them about the program.

Commitment of Single Practice Member:
Referrals: Doctors were not asked to sign up for collaboration, but were encouraged to participate in the referral system.

Single Practice Member Perception of Value of Model: Some single practitioners were happy to refer patients to the DOT centers when they were informed of the location of the centers and observed that this would be a long-term initiative.

Results: The NGO DOTS clinics were well-functioning after one year of the project. The links with the private sector were still mostly informal and sporadic. The majority of doctors did not want to comply with a uniform system of recording or referrals. Not all doctors were willing to learn about the services linkages or to follow the program in the manual. One observer said: "Many still don't know about treatment regimes and how to refer. They do not bother, it is easier to start treatment."

No chest symptomatics were referred for free sputum examination from the private sector to the service set up by the program.

There was no major shift of patients from the private to the public sector during the first eight months. In total, 39 (8.6%) patients were referred from private practitioners; 14 of these were referred by practitioners affiliated with the NTP or one of the DOTS clinics. Many patients referred to DOTS clinics from private practitioners never returned to the private doctor, hence the private practitioner lacked feedback. No formal system was in place to report the referred patient's progress to the private practitioner.

Lessons Learned:

Not all practitioners are willing to refer. In Nepal, doctors were reluctant to refer because it would then appear the doctor was not competent to provide treatment. Some doctors also felt it would be strange to send a patient that had come to the private sector for privacy or convenience to a public clinic. The private practitioners – many of whom had also worked in the public sector – didn't trust the public sector to provide better services than they could.

Doctors were reluctant to keep records because it was burdensome, there was no working system to accept and use the data in records, and doctors felt the records could be used for tax purposes. Instead, they relied on the report that patients were required to carry.

Government will in a services linkages system is not enough. A services linkages system needs continued, respected leadership and the resources to interact regularly with the private sector. (In the Nepal case, there weren't enough resources and there was a lot of turnover in public sector personnel.)

In Nepal, the public sector had no power to provide positive or negative incentives to the private sector to engage in the delivery of appropriate TB services. Researchers on the project felt a "mediator" between the public and private sectors was important. The mediator could be either an international research institution or an NGO.

One analyst concluded that it might be better to find and upgrade institutions with the organizational capacity and interest to be involved in TB control (such as NGOs) rather than trying to change the behavior of private doctors. (Hurtig et al)

Sources:

1. "TB and Health Systems Development," December 2002, Nuffield Institute of Health. (newsletter)

2. Hurtig, Anna Karin, Shanta B. Pande, Sushil C. Baral, James Newell, John Porter, and Dirga Sing Bam, "Linking Private and Public Sectors in Tuberculosis Treatment in Kathmandu Valley, Nepal," Health Policy and Planning, 17(1):78-89.

Single Practice Profile

Model Name: Pakistan Green Key Social Marketing (KSM) Network

Model Type: social marketing project

Health Services Delivered: family planning - hormonal contraceptives (orals and injectables), marketed under an "umbrella brand"

Provider Type(s): doctors, paramedics, chemist shop workers

Number of Providers: 5,422 doctors, 4,483 paramedics, 6,920 chemist shop workers

Member Recruitment/Selection Criteria and Process: The network preferred experienced and established providers. Greenkey providers sampled by an outside reviewer were mostly in their late 30s, early 40s, with 12-15 years of professional experience. More than 80% owned their clinics, another selection criteria as evidence of commitment to clinic success. (Montagu)

Services Provided by Support Entity:
Medical Training: The project provides initial and refresher training; training is task-based and delivered in a scenario-specific context. Role plays help providers develop the communications skills they need. The course for doctors and paramedics is 12 hours; the course for chemist shop workers is shorter. Refresher training is offered 2-4 weeks after the monitoring visit, and is attended by about half of those invited to it. (This represents about 1/6 of the trainees since 1/3 of the trainees get monitored and ½ of these accept refresher training.) Mystery client observation of provider behavior identifies weaknesses that are then addressed in subsequent training. KSM provides laminated checklists of contraindications, and replaces these if necessary during monitoring visits.

Supervision/monitoring: About 1/3 of KSM-trained doctors and paramedics receive active follow-up. These are visited in their clinics about once per year. A KSM trainer runs through a monitoring interview, reminds providers of good practices, replaces signboards if necessary, invites the provider to refresher training, and requests feedback on the project from providers. Monitors do not directly observe actual client visits since many providers see less than one family planning client/day. Mystery clients visit small numbers of providers to observe provider behavior. Information from the mystery client visits is used in refining the training programs.

Branding: Trained providers can display Key signs outside their clinics to advertise their association with the widely advertised Key brand. Signboards are replaced if necessary by trainers during the monitoring visits.

Marketing: The Key brand is widely marketed.
Client Perception of Model Participants: Clients of Key providers are more likely to feel satisfied with the information they receive than clients of non-Key providers (93%

vs. 81%) and are more likely to report having been very well treated (71% vs. 63%). ("Private Sector Providers…")

Single Practice Member Perception of Value of Model: A study of the providers found that training was rated most often as the most important benefit of membership in the KSM program. ("Private Sector Providers…")

50% of members cited training as the most important benefit of membership; 12% cited improved skills; almost 10% cited interaction with other providers; under 10% each cited subsidy, increased clients, knowledge of service competitors, and advertising. (Hetherington)

Results: The percentage distribution of respondents who reported receiving FP services during their last visit from any outlet in an urban area was: 55% from government; 40% from commercial; 1.5% from GreenStar; .9% from Key. (Hetherington)

In a study, almost 80% of clients recognized the Green Key logo. Approximately 82% of knowledgeable clients associated the logo with family planning services; 30% with Green Key products. Client education was more important to recognition of the logo than age or income. (Tsui)

Lessons Learned: Provider interviews are not a good enough proxy for provider behavior because there are differences between what a provider reports and what s/he actually does in client consultations. Mystery client visits are necessary if quality is to be assessed accurately. Information from these can help refine the training program.

Based on studies of GreenStar, GreenKey, and Janani, clients are poor judges of provider quality. There was no correlation between provider service quality score and client ranking of provider quality. (Montagu)

Sources:

1. "Private Sector Providers: Do They Behave the Way They Say They Do?" Futures Group Briefing, January 2003.

2. Tsui, Amy, "Franchise Branding: Benefits and Challenge," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

3. Hetherington, John, "Greenstar KAP: Reproductive Health and HIV/AIDS Survey," presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

4. Montagu, Dominic, "Provider Motivation in Social Franchises," presentation at the meeting on Social Franchising of TB and TV/HIV in Low Resource Settings, The Rockefeller Foundation, New York, April 28-29, 2003.

Single Practice Profile

Model Name: Pakistan Green Star[1]

Model Type: social franchise

Health Services Delivered: Family planning and reproductive health. The project started with IUD training and supply, then expanded to include oral contraceptives and injectables. The latest Green Star Strengthening Project is working to expand Green Star's inventory of products and services to meet broader RH health needs and to attract more clients. It now covers emergency contraceptives, voluntary surgical contraception, antenatal and postnatal care, post abortion care, clean delivery kits, and RTI and STI treatment. (Ahmed and Hetherington)

Start Date: 1995 (Social marketing of condoms started in 1987. The development of the network started in 1995.)

Provider Type(s): male doctors, female doctors, junior paramedics, and pharmacies.

Number of Providers: 13,000 providers in 40 cities

Member Recruitment/Selection Criteria and Process: The network preferred experienced and established providers. Green Star providers sampled by an outside reviewer were mostly in their late 30s-early 40s, with 12-15 years of professional experience. More than 80% owned their clinics, another selection criteria as evidence of commitment to clinic success. (Stephenson)

Contacts were made with health professionals through the Pakistan Medical Association, whose endorsement has been important to the program's credibility. (Ahmed and Hetherington)

Originally, Green Star worked only with female general practitioners (GPs). It worked with females because only females were allowed to insert IUDs in Pakistan. It worked with GPs so clients could visit a doctor who provides a broad range of health services and not be seen as seeking stigmatized family planning services.

Recruitment started by getting addresses of doctors from medical associations and pharmaceutical companies, then mapping out locations. Franchise staff visited clinics to assure the clinic met basic minimum standards. Then doctors were interviewed/screened. The first recruits, who started before there was any publicity for the brand, joined because they were interested in the training. Now, there is a waiting list to join the franchise.

[1] The CMS study of Green Star is the most comprehensive study of a franchise available. The Green Star franchise is one of the longest-lived, largest, successful, and well-developed franchises in the developing world. Readers are encouraged to read McBride, Julie and Rehana Ahmed, "Social Franchising as a Strategy to Expand Access to Reproductive Health Services: A Case Study of the Green Star Service Delivery Network in Pakistan," CMS Technical Paper, September 2001, available at www.cmsproject.com.

Services Provided by Support Entity:
Medical Training: Ten half-days of competency-based training are provided. (The program originally provided five full days, but shifted to half days to accommodate practicing doctors). Pharmacists receive a half-day of training in the importance of family planning, hormonal contraceptives, management of side effects, and recommended referrals. Junior paramedics receive a one-day training. Green Star has hired doctors to provide training and then monitor their trainees.

Trainees who pass the test receive a certificate and are invited to join the franchise.

Franchisees are able to attend refresher training at any time.

Other Training: The Green Star Strengthening Project offers training in record keeping. It plans to introduce a business management module to the training curricula.

Supervision/monitoring: The trainer, who is generally held in high regard by the trainee, visits the trainee on a regular basis to monitor performance and answer questions. As franchisees become confident and proficient, monitoring and support visits decrease in frequency but are never discontinued. Supplies and signage are provided during the monitoring visits.

Franchisees also can get technical assistance via a 24-hour telephone hotline.

In addition to monitoring visits, Green Star uses periodic mystery client surveys.

Supplies: The franchise provides subsidized contraceptives to franchisees. Once the franchise agreement is signed, Green Star provides the new franchisee with physical upgrades to conform to franchise standards (painting of the facility or provision of essential equipment), signage, IEC materials (including a counseling flip chart), and family planning product samples. Doctors and paramedics who have been trained to provide IUD services receive IUD instrument kits and sterilizers.

Branding: The Green Star logo is widely marketed and recognized.

Marketing: The Green Star logo is heavily promoted. The Green Star Strengthening Project holds Mohallah (neighborhood) meetings, free medical camps, community events (like sponsoring wrestling matches), visits from community motivators, working with opinion leaders, a mass media campaign, and outdoor advertising with posters and billboards. Recently, the project has shifted successfully to general BCC addressing family planning concerns to get over plateaus in sales.

Research: Green Star Strengthening Project has done operations research including a KAP study. (Ahmed and Hetherington)

Commitment of Single Practice Member:

Reporting: Members report sales and activities to the franchise.

Referrals: Yes – lower level members refer patients to doctors for clinical procedures.

Membership or franchise fee: Green Star is just starting to introduce a franchise fee.

Input into decision-making or model: Health care providers were included in the development of the service delivery protocols and training curricula.

Client Perception of Model Participants: 70% of Green Star clients rated franchise quality as high; 77% rated franchise cost as medium. (Hetherington)

A study of Janani, Green Star and Biruh showed that clients at franchises are more willing than are clients at non-franchise private establishments to use the same establishment for their next visit, less likely to cite affordability, and more likely to visit for FP, RH, MCH and medicines than for general care.(Bardsley)

Single Practice Member Perception of Value of Model: 40% of members cited increased clients as the most important benefit of membership; 20% cited training; 15% said subsidy; under 10% each for interaction with other providers, knowledge of competitors, improved skills, and advertising. (Hetherington)

An outside study found that incomes for family planning services are large and these services have shown themselves to be highly profitable in this and several other franchise settings. (Stephenson)

Results: The cost of a Green Star CYP is the lowest in the country and one of the lowest in the world. Green Star provided 22% of all modern contraceptive methods to low income consumers in 2001. Overall, Green Star-provided CYP increased by 25% between 2000/01 and 2001/02. In 2002, it provided 1.6 million CYP. (Ahmed and Hetherington and Moore)

The network generates 10 million client visits/year; sales of oral contraceptives nationwide jumped from 1.9 million to 4.5 million between 1994 and 2000.

Green Star client KAP showed higher current use of every category of modern, temporary family planning methods than the national statistics. (Hetherington)

94% of community representatives recognized the Green Star brand. 82% of community representatives heard about Green Star on TV; 49% from their medical provider; 29% from a friend, family or neighbor. (Hetherington)

In a study, 80% of clients recognized the Green Star logo. Approximately 85% of knowledgeable clients associated the logo with family planning services; 33% with Green Star products. Client education was more important to recognition of logo than age or income. Branding significantly increased a client's odds of going to a Green Star site for

RH services. Branding also significantly increased use of franchise sites for RH and non-RH services by being associated with FP services, products, and accessibility. (Tsui) Percentage distribution of respondents who reported receiving FP services during their last visit from any outlet in an urban area was: 55% from government; 40% from commercial; 1.5% from Green Star; .9% from Key. Green Star appears to be succeeding in shifting clients to modern methods, but still touching only a small percentage of the population. (Hetherington)

An analyst concluded: the Green Star franchise adds value among providers and clients; consumer trust in temporary modern methods appears to be increasing, possibly attributable to increased access and Green Star and others' BCC campaigns; BCC campaigns are reaching their target audiences (many have heard of Green Star); and Green Star clinics could benefit from increased brand support. (Hetherington)

Lessons Learned:

Model Development:
All aspects of the franchise operations should be field tested and optimized before expanding the model. A franchise is designed to rapidly expand a proven business model. Before expansion, the model must have been carefully tested.

Initial buy-in and endorsement of key stakeholders lends credibility to the franchise and facilitates its growth. Involve credible institutions like the local medical association in the design and seek their endorsement. Submit service delivery protocols to the medical association for its review and approval. Involve franchisees in on-going refinement of the program and training curricula.

When dealing with a sensitive health issue (like a stigmatized disease or reproductive health services in some countries), bundle the service with more general health services so clients do not have to worry about being seen at the facility.

Before designing the functional components of the franchise, clearly define the service being franchised. (Example: don't go into aspects of quality of care not specifically related to the services being franchised.)

A fully functional and reliable management information system must be in place before implementing the franchise so that data can be recorded accurately from the beginning of the project and proper monitoring and evaluation can occur.

Branding/Promotion:
A critical mass of 150 franchisees was established and operating in Karachi before the advertising campaign was launched. This figure for critical mass was an estimate of the minimum number of provides necessary to meet initial demand created by the campaign. (McBride and Ahmed)

Brand development should accommodate possible expansion of the franchise into new health product categories, such as nutritional supplements. For example, Green Star's brand is associated with "trustworthy family planning," and therefore cannot be extended to nutritional supplements or HIV/AIDS prevention. It will have to develop and build equity in a new brand to accommodate these new services.

To the extent possible, community-based activities (involving network members) should be incorporated into strategies to create demand. These can convey more in-depth information than the mass media, and can more closely tie providers to the network.

Signboards should be designed so they are attractive and efficient to produce (no customization); systems for installing and maintaining signs should be in place before expanding the franchise.

Membership:
In building the franchise, emphasize the quality of providers recruited rather than quantity.

The network started with MDs but expanded to include pharmacies because pharmacies are an important first source of family planning information for consumers and could heavily influence their decision to adopt family planning. Including pharmacists greatly expands dissemination of accurate FP information, expands sales of Green Star products, and facilitates referrals to appropriate Green Star providers.

Junior paramedics were included because low-income people go to paramedics for treatment. They work in the poorest neighborhoods and can have a larger clientele than doctors.

While the average franchisee has a number of years of experience, the franchise likes working with newer doctors who are very interested in Green Star's marketing services.

A franchise dues system – however minimal – should be established from the outset of the project. This helps screen out franchisees that are not serious, makes franchisees feel vested in the network, and helps with cost recovery. Once the franchise is well underway, it will be difficult to get franchisees to pay for something they're used to getting for free.

While overall provider skills are much improved, quality varies considerably among providers. Similarly, some providers charge above the agreed-upon price. The program attempts to deal with these issues by offering remedial training and encouragement, and removing the signboard from problem outlets. It has not penalized poor performers. Its system for dealing with sub-standard performance is being reevaluated.

It's hard to sustain provider interest in staying in the network. (After a certain amount of time, the provider is probably benefiting more from client referrals than from marketing, and, so, would be less interested in the network. This may make it difficult to introduce franchise fees to long-established members.)

Care should be taken to provide ongoing motivation to franchisees. Motivate providers by recognizing them publicly in ceremonies with distinguished guests. Involve members in interesting seminars, and solicit their ideas for the network.

Training:
A quality training program is essential since quality of services builds demand for the franchise and since training is one of the most valued services provided to franchisees by the franchiser.

The franchise needs a system for tracking remedial training and regular practice with new, though infrequently used, clinical methods.

Monitoring:
The network cannot provide adequate monitoring (one visit/month) to every member. This has led to a certain loss of control over quality. It attempts to deal with this by:

- Focusing monitoring visits on problematic outlets
- Organizing meetings with high and low performers to understand the elements of success and poor performance
- Facilitating popular community events that generate demand and enhance provider commitment to the network.

A strong support and monitoring team large enough to cover franchisees adequately and with appropriate frequency is necessary to control quality.

Data collection requirements from providers should be kept to a minimum and forms should be simple and easy to complete.

Quality:
Female providers have been more effective than male providers. They've generated the highest sales, have best accommodated Green Star's protocols, and work in the poorest neighborhoods.

A contractual agreement that clearly stipulates the roles and responsibilities of franchiser and franchisee and that outlines enforcement mechanisms is necessary but not sufficient for maintaining control over quality of services. The contract must be balanced with the need to make membership appealing so members will want to comply.

Based on studies of Green Star, GreenKey, and Janani, clients are poor judges of provider quality. There was no correlation between provider quality score and client ranking of provider quality. (Stephenson)

Sources:

1. Bishai, David. 2002. "Improving Quality and Access in Private Sector Primary Health Care – The Role of Business Models." World Bank.

2. Tsui, Amy, “Franchise Branding: Benefits and Challenge,” presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

3. Hetherington, John, “Green Star KAP: Reproductive Health and HIV/AIDS Survey,” presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

4. Ahmed, Rehana and John Hetherington, “Green Star Strengthening Project,” presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

5. Bardsley, Phil, “Franchise Quantity and Quality Outputs: Evaluation Results,” presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

6. Stephenson, Rob, “Cost Analysis of ABM Data,” presentation made at the Third Annual Meeting of the Alternative Business Models for Family Planning Services Delivery Project. November 7-8, 2002, Washington, D.C.

7. McBride, Julie and Rehana Ahmed, “Social Franchising as a Strategy to Expand Access to Reproductive Health Services: A Case Study of the Green Star Service Delivery Network in Pakistan,” CMS Technical Paper, September 2001.

8. Moore, Joanne, “Franchising of Health Services: The PSI Experience,” presentation to the Technical Seminar on Franchising of Health Services, Washington, D.C., 22 May 2003.

Single Practice Profile

Model Name: Uganda Midwives microfinance scheme

Model Type: microfinance and business training for midwives

Health Services Delivered: reproductive health

Start Date: January 2001

Provider Type(s): The program originally focused on midwives, but later included nurses, clinical officers, and doctors.

Number of Providers: 280

Member Recruitment/Selection Criteria and Process: At first, loan recipients were identified through professional associations (like the Uganda Private Midwives Association), but the loans were later made available to all private providers.

Services Provided by Support Entity:
Medical Training: Clinical training was not provided. Providers were taught that increasing client satisfaction by improving the quality of services offered was important. Ways discussed to improve quality included better client-provider interaction, availability of drugs and supplies, hygiene and sanitation, confidentiality, affordability, and accessibility. Also providers were introduced to the family planning products sold by CMS in country.

Other Training: The program provided five days of business skills training. This included business planning, record keeping, financial reporting, credit management, and marketing. Client satisfaction with services was highlighted as a critical component of marketing.

Supervision/monitoring: One follow-up clinic visit was made to determine if midwives were implementing the business skills taught in training. The monitors checked for cleanliness, client privacy, availability of drugs and basic supplies, placement of clinic signboards to make clinics more accessible, and record keeping. The project also conducted client-exit surveys to obtain the client's perspective. The monitors' dialogue with the providers during the monitoring visit reinforced providers' awareness of factors that determine client perceptions of quality.

Credit: Original loans were for an average of $454 at a standard interest rate; second loans for an average of $742 were available for clinics who repaid the first loans. Loans were given on the principle of group lending.

Client Perception of Model Participants: Overall, the intervention had a net positive impact on six out of eight indicators of perceived quality. At intervention clinics, there

were significant increases in the percentage of clients who reported the availability of drugs (23 to 37 percent), fair charges (18 to 28 percent), privacy (4 to 8 percent), accessibility (43 to 50%), good physical outlook of the clinic (3 to 7 percent), and the range of services offered (12 to 18 percent) as reasons for their preference of these clinics over others. The percentage of clients who reported always visiting the intervention clinics increased from 38 to 45 percent.

Results: The intervention resulted in a significant net improvement in clients' perceptions of the quality of care received at intervention clinics. The intervention was also associated with a higher level of client loyalty.

There was a significant increase at intervention clinics (from 30 to 39 percent) in the proportion of clients who obtained preventive MCH services (ANC or postnatal care, immunization, delivery care, child nutrition advice, and family planning).

Midwives used the loans to purchase drugs (including at wholesale prices, allowing one to lower the cost of her drugs), increase the number of rooms in the practice, and display signboards (increasing accessibility). Some also used the loans to purchase supplies to improve infection control at their clinics.

Lessons Learned: A microfinance program that provides business-skills training and revolving loans to small-scale private providers, such as midwives, can increase client loyalty by increasing client perception of quality of care. Credit and business skills can help providers improve the quality of their services and increase the range of services they offer. Practice viability can be increased by increased client flows (from greater client loyalty and clinic reputation for quality services), increased sources of revenues (from an increased range of services and consistent availability of drugs), and higher provider savings resulting from improved business management skills.

Sources:

Agha, Sohail, Asma Balal and Francis Ogojo-Okello, "The Impact of a Microfinance Program on Client Perceptions of the Quality of Care Provided by Private Sector Midwives in Uganda," CMS Country Research Series, Number 6, October 2002.

Single Practice Profile

Model Name: Zimbabwe Voluntary Counseling and Testing Services for HIV/AIDS

Model Type: Franchise based on a memorandum of understanding between a support entity (PSI) and existing public, commercial, and NGO providers.

Health Services Delivered: HIV/AIDS voluntary counseling and testing

Start Date: 1998

Provider Type(s): public, commercial, and NGO clinics

Number of Providers: 9 clinics

Services Provided by Support Entity:
Marketing: PSI uses mass marketing to create demand through IEC about VCT. The IEC campaign has three phases: (1) a basic campaign to create awareness of VCT and identify the sites; (2) a more nuanced campaign that promotes the counseling aspect of the project (to respond to 98 percent of the clients who believed the centers are for testing only); (3) a testimonial phase, emphasizing client satisfaction with services, coming to terms with fear, etc.

Research: The support entity provided formative research into awareness and perception of the VCT concept, attitudes to knowing HIV status, what people wanted in VCT services, etc.

Results: After 1.5 years, the clinics were seeing about 800 new clients (combined) every month. After PSI opened its own very centrally located site with dedicated staff and extended hours, new clients surged. The PSI-managed site alone takes in about 1,500 new clients/month.

Lessons Learned:

For a new health service area, as opposed to an established health service area, mass media can play a significant role in increasing client inflow. The Zimbabwe program's two original advertising campaigns led to significant increases in new clients.

A health service addressing an illness associated with a stigma will not be promoted by word of mouth very effectively, so it's necessary to rely on media.

In general, if there's a substantial demand for a service, then promote the providers. If there's not yet substantial demand for a service, promote the service before you promote the providers (or at least promote the service and the providers simultaneously).

In Zimbabwe (as in many countries), it's illegal for health providers to advertise. It is legal, however, to advertise a branded network. Use of logos in the advertising campaigns and at the network sites allows for effective promotion of the providers.

Originally, PSI (the support entity) did not directly control or manage any of the sites. Rather, VCT services wee added to existing private, public and NGO settings. PSI had a memorandum of understanding with each site, but it was difficult to enforce the agreement. The lack of management control over personnel and organizational priorities led to a host of program management and operational issues. Later, PSI opened a site that it directly controls and manages. PSI is able to use the site it directly controls and manages as a laboratory for new initiatives (testing impact of extended hours, price, promotion, training, etc.)

Location is critical. One centrally located center in a big city can provide services to more new clients every month than can ten centers across the country. Locate in a central business district if possible.

The centers charge for testing and counseling. Occasionally, PSI runs a free promotion to bring in people who are otherwise unwilling to pay for services.

Sources:

"Marketing Reproductive Health Services: Moving Beyond Traditional Social Marketing," Technical Advisory Group Meeting, CMS, May 3, 2001.

C. Lessons Learned and Recommendations for TIPS

Success in supporting private practitioners' contributions to improved health outcomes requires targeting particular constraints given the nature of the health service being provided, the nature of the market, and the needs of the service provider. The lessons learned and recommendations for TIPS provided below reflect these considerations.

C1. Lessons Learned

The Health Service Being Provided. One must understand basic issues regarding the new health service to know how to generate demand and structure an appropriate private sector model. Basic issues include:

- How well understood are the health issue and prevention or treatment options?
- Which segments of the public are being targeted by the program?
- What level of health care providers will clients most likely approach for services to address the health issue? Who is allowed to provide these services?
- Do any cultural constraints impact clients' freedom to seek services openly?
- How well do health practitioners understand the health issue and prevention and treatment options?
- What are the challenges in getting health practitioners to provide quality services? Where are the gaps?
- Do benefits from prevention or treatment accrue mostly to the individual or to the public at large? How compelled are clients to seek assistance?

Lessons learned in demand generation and developing quality service provision models build on the answers to these questions.

Demand Generation

In a number of cases, efforts to support single practitioners have led to significant, successful programs that touch large segments of the population. Green Star practitioners, for example, have 10 million client visits per year and have provided 1.6 million CYPs, at some of the lowest costs in the world. The India Janani program provides almost one million CYPs in one year. Members of a number of these programs had high client return rates and a client base that cited quality as a reason for using their services.

Awareness. If a health issue is poorly understood, a significant campaign to raise awareness of the issue and its prevention or treatment will be needed to generate demand for services. As the Zimbabwe VCT program understood, treatment of a disease associated with a stigma will not be promoted by word of mouth from satisfied clients, so mass media or community events are especially important. Mass media campaigns, especially with endorsement from widely recognized and respected leaders or celebrities, establish credibility for the health message..

Promoting Trained Practitioners. Generic awareness campaigns – as in India's Goli ke Hamjoli campaign -- have helped boost interest in/sales of commonly known and widely available health products. Awareness campaigns for a relatively new health service or product must direct patients to quality providers. The Kenya Nyanza Province Private Treatment of STIs training program failed to publicize the updated skills of its trainees. Clients didn't know where to go for better treatment and the program had minimal impact initially. It's important to identify qualified providers with a logo or brand and direct the public to them by promoting the logo or brand.

Large mass media campaigns promoting a logo or brand may not be feasible in early pilot stages because there may not be enough qualified and branded providers to meet the demand generated by a mass media campaign. In the interim, efforts like the India Janani, Pakistan Green Star, and especially the Nepal nurse and paramedic franchises have shown that training providers to promote their own services and community events publicizing the health issue and service can be very effective. These measures can fill the gap for demand creation before mass media promotion of the brand is feasible.

Dealing with cultural issues. Some health issues and services are highly stigmatized in certain countries. While clinics can advertise their ability to provide these services, the stigmatized service should be one of a broader range of services offered so patients are not reluctant to be seen visiting the clinics. The Pakistan Green Star franchise understood this from the start, and prepared general practitioners to provide reproductive health services so patients felt comfortable visiting their clinics.

Similarly, cultural sensitivity to, for example, the sex of service providers has to be taken into consideration in developing programs if clients are to feel comfortable seeking help. For example, in cultures where women would only go to a female doctor for gynecological services, it would waste resources to train male practitioners to insert IUDs.

Developing Quality Service Provision Models

Quality service provision models must attract and select appropriate practitioners, train them, ensure they provide high quality services, and retain them in the program.

Attracting and Selecting Appropriate Practitioners. Because clients who avail themselves of private sector services have the ability to choose their service providers, single practitioner programs must start by understanding which level of provider will be sought by the targeted public. Programs should be built around this. For example, the India Janani program started with Surya clinics and Titli centers, but then expanded to shops when it was recognized that many clients in rural and poor areas went first to shops.

Once the level(s) of providers is understood, programs may need to identify appropriate subsets of practitioners within that level. The Indian Medical Association training failed to target practitioners who served rural areas, so its goal of expanding access to

reproductive health services was not met. The Pakistan Green Star program recognized that women could only receive certain reproductive health services from female doctors, so it first targeted only female practitioners.

It is difficult to recruit practitioners to a new, unproven program, especially if that program addresses health issues not well understood. Programs may have to attract members to deal with a stigmatized disease in advance of a major awareness campaign. High level support for the initiative and recognition of pioneer members may be helpful in attracting interest in the early difficult recruitment stage.
Programs like Pakistan Green Star and India Janani, have struggled with this and concluded it was a mistake to focus on quantity of members over quality in the initial phase. Paying promoters for each new member recruited, as was done with India Janani, has yielded a membership of widely varying quality, to the detriment of the program's reputation.

Private practitioners in most developing countries have little if any access to continuing medical education. Program members in countries as diverse as India and Kenya have generally placed greatest value on the training they receive through programs. Lower level practitioners also value enhanced prestige in the community that accompanies training and participation in a quality program. Program designers can emphasize these elements when recruiting private practitioners to their programs.

Training. Training is the heart of most programs to enhance practitioner provision of improved health services. Program developers should recognize that most private practitioners will have had no training beyond their original degrees, unlike public sector practitioners who may have received in-service training or benefited from donor-funded programs. Developing a high quality training program will be important in attracting members and essential to ensuring quality services. Counseling is an essential element. All the usual advice regarding training -- starting with a sound training needs assessment, ensuring trainers are highly skilled in the training topic and in training adults, incorporating a competency-based training program, ensuring adequate practice of challenging clinical skills, etc. – hold true as much for the private sector as for the public.

Programs have learned it's important to focus training only on services appropriate to the level of the trainee. For example, the India Janani program oriented shopkeepers and Titli center staff to abortion and other clinical procedures, which were to be provided only in the Surya centers. Rather than referring patients to skilled practitioners in the Surya clinics for these procedures, the shopkeepers and Titli staff attempted the procedures themselves. Program managers have learned a little knowledge can be very dangerous.

Include practitioners or their representatives (such as the relevant practitioner associations, as was done in Pakistan Green Star) in developing the training program to lend it credibility and attract interest.

Programs that focus on private practitioners sometimes provide non-medical training to good effect. In the Nepal nurse and paramedic franchise, training in reproductive health

was complemented with training in how to market services and the importance of word of mouth recommendations. Understanding the business imperative of a strong reputation raised members' appreciation of the importance of quality. Training in basic business management skills in Uganda helped practitioners grow successful businesses that could purchase better medical equipment and high quality supplies and introduce better infection prevention practices.

Ensuring Provision of High Quality Services and Adherence to Standards. Ensuring adherence to standards is a challenge in both public and private programs. There is often no automatic correlation between successful completion of training and implementation of improved practices in the clinic. Some level of on-going monitoring is necessary, and mystery client approach are invaluable in assessing actual clinical performance. While monitoring is costly, it is essential to maintenance of standards and the reputation of the program. Programs can try to achieve some program efficiencies by combining monitoring and materials supply (drugs, IEC materials, signage, etc.) during monitoring visits, as has been done in the Pakistan Green Key, Pakistan Green Star, and India Janani models. Also, very large models like India Janani have found it useful to widely publicize information on quality treatment so the public knows what to expect. The more the public knows about high quality health services, the better it will be able to serve as a watchdog over practitioner performance.

Programs that certify and promote member services have an important tool to ensure adherence to standards: members can be removed if standards aren't met. The contract with members should specify standards and the consequences of not meeting them. The India Janani franchise includes standards for minimal sales and services quality. It maintains a waiting list of potential members, so members who don't meet standards know they can be removed and replaced readily.

Referrals. Referrals are often another weak link in health programs, as most providers are reluctant to send patients to others. This was seen in both the Nepal TB public-private partnerships program and the India Janani franchise. This can be more of a problem in profit-driven service provision than in the public sector. Commissions for referrals help only modestly. As was seen with India Janani Titli centers, practitioners can prefer to receive the full price for performing a service that should be referred in lieu of receiving the smaller commission for a referral.

It can be helpful to engage representatives of the various levels of the health system in extensive dialogue to plan the referral system. This should help garner buy-in. Once a referral system has been agreed upon, it should be widely publicized to enhance practitioner adherence. Monitoring of referrals should form an important part of the monitoring program and contract with members.

Retaining Members

Programs like India Janani, Pakistan Green Star, and Ethiopia Biruh Tasfa have found it's hard to sustain some members' interest in and commitment to the program over time.

Ultimately, private practitioners stay in a program that provides professional gratification and enhances their businesses. Maintaining the program's reputation for quality health services is essential. Members will desert a brand that's not widely known or respected.

Requiring members to pay even a modest franchise fee serves as an indicator of their motivation and invests them in the program's success. It's difficult to introduce a membership fee after the program has been in operation for a while, so this should be done up front.

Recognize that the lower level of service providers will feel they stand the most to gain from their membership. If retaining the higher level members' participation is really important, focus attention on their needs and interests and engage them closely in helping develop and refine the program.

Allow the program to mature and evolve to better need the country's health needs and members' needs. Most programs have expanded the range of health services they offer over time, recognizing that this enhances both their contribution to the country's health needs and the value of the program for members.

Thought should be given at the outset to whether the skills and systems learned for provision of one specific health service might eventually lend themselves to other health services. If this is a possibility, care should be taken to establish a broad brand identity and logo. The widely recognized Pakistan Green Star brand focused on reproductive health only and it cannot now be expanded to cover other services. That program now has to start from scratch to create and market a new brand for a wider range of services.

Sustainability

While few of the case studies explicitly examined sustainability, it is possible to draw some conclusions for these experiences. Programs benefit from having local institutional homes – be it the Pakistani social marketing foundation, the Indian Medical Association, or the Kenyan Kisumu Medical Education Trust. These provide the program indigenous roots and a long-term institutional base that should survive the donors' interest. In addition to their health goals, private practitioner programs are intended to help generate income for their members. Some of that income can be funneled back into the program through membership or franchise fees, purchases of supplies, or interest on loans to help make the program self-sustaining.

C2. Recommendations for TIPS

Based on the lessons learned in the case studies examined here, it is possible to make a number of recommendations for TIPS' consideration. Obviously, the TIPS team should view these through the prism of its own detailed understanding of the situation and needs impacting DOTS in the Philippines.

Training, monitoring, a referral system, branding and significant promotion of DOTS in general and the brand specifically will be important elements in creating robust supply and demand for private sector DOTS delivery in the Philippines. Unless the public sector takes responsibility for any of these, TIPS will need a model that offers these five elements. A fractional franchise might best meet this need. The recommendations offered below could best be packaged in a franchise, but could also be advanced independently.

- **Raise awareness**. Accompany any program with general awareness campaigns about TB and DOTS, targeting both the public and health practitioners.
- **Identify and promote qualified practitioners**. Awareness campaigns should indicate where quality DOTS services are available, probably through promotion of a brand that indicates trained and monitored practitioners.
- **Create a general brand**. The brand and logo might be associated in the first instance with TB treatment, but be general enough to eventually accommodate other health services.
- **Promote at the community level**. During the pilot phase, it will probably be necessary to promote the brand at the community level. Even later, community events can be very effective and elevate the profile of qualified practitioners in the community.
- **Provide DOTS alongside other services**. Make sure that DOTS can be sought in venues that offer a range of health services so patients do not feel their visits to these venues advertises that they have TB.
- **Focus on quality rather than quantity in selecting members**. Select practitioners for the program carefully. Select the appropriate level of practitioner, and then select among that group for quality.
- **Build member commitment to the program**. Publicize the very high level of interest in DOTS to enhance its appeal to potential members. Ask members to pay a fee or otherwise signal their investment in the success of the program.
- **Emphasize training**. Create a top-notch and respected training program. Include general skills like records management that will improve DOTS and the practitioner's general practice.
- **Integrate standards into contracts**. Write specific standards and penalties for not meeting them into contracts with members.
- **Plan the referral system carefully**. Engage various levels of the health professions in planning the referral system. Include referral standards in the awareness activities for health professionals and in the standards for members.
- **Develop a rigorous monitoring program**. One of the biggest challenges in this will be keeping its costs down while ensuring its effectiveness.
- **Engage members as real partners** in the program, including processes whereby they have input into the programs evolution and growth.
- **Build the program within a local institution** and include association members to ensure sustainability.

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